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ABSTRACT

It has generally been accepted that brief interactions with counselors can provide significant mood or symptom improvements in potential psychotherapy clients. Of primary importance appears to be the reduction of anxiety and depression and, consequently, the activation of hope which may be triggered simply by the act of being interviewed by a mental health worker and the anticipation of future professional care. It is possible, however, that the importance of a single intake interview has been overrated. To examine this issue, 126 individuals who sought counseling at a university counseling practicum clinic were told they would be assigned to a counselor other than the intake counselor when one became available. Subjects completed demographic questionnaires and checked and rank ordered their perceptions of presenting problems. Subjects were assigned to one of two treatments, receiving either an assessment battery consisting of the Beck Depression Inventory and the State-Trait Anxiety Inventory-State for an intake interview first. The results revealed no significant differences in client anxiety or depression as a result of the experimental manipulation. Anxiety and depression were not decreased as the result of intake interviews. These findings have implications for clinic directors who must decide when to conduct intake interviews with clients on a waiting list. (NB)

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Effects of an Intake Interview on Clients' Anxiety and Depression

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Running Head: EFFECTS OF AN INTAKE INTERVIEW

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Abstract

It has generally been accepted that brief interactions with counselors can provide significant mood or symptom improvements in potential psychotherapy clients. Of primary importance appears to be the reduction of anxiety and depression and, consequently, the activation of hope which may be triggered simply with the act of being interviewed by a mental health worker and the anticipation of future professional care. It is possible, however, that the importance of a single intake interview has been overrated.

Anxiety and depression were not decreased as the result of intake interviews in this study. Perhaps talking about presenting problems with an intake counselor may actually serve to intensify symptomatology in some clients rather than to reduce it. Implications for clinic directors who make decisions regarding when to conduct intake interviews with clients on a waiting list are discussed.

Effects of an Intake Interview

on Clients' Anxiety and Depression

For over two and a half decades, it has generally been accepted that even brief interactions with counselors can provide significant mood or symptom improvements in potential psychotherapy clients (Frank, Gliedman, Imber, Stone, & Nash, 1959). Of primary importance to these researchers, and also to the clients whom they observed, appears to be the reduction of anxiety and depression and consequently the activation of hope, which can be triggered simply with the act of being interviewed by a mental health worker and the anticipation of future professional care (Frank, 1974; Stone, Frank, Hoehn-Saric, Imber, & Nash, 1965). These researchers state that activation of hope in those individuals who have suffered from a variety of cognitive, affective, or behavioral problems can help provide the impetus to reverse previously maladaptive lifestyles.

Symptom relief in itself is generally considered an important virtue of therapy. Specifically, lowered feelings of depression and reduction in anxiety provide intuitively appealing accolades, especially important for potential psychotherapy clients. Evidence supporting this point of view was reported by 43 outpatients who had experienced brief therapy at a psychiatric clinic. The greatest amount of change reported was in the area of patients' self-ratings of depressive pathology (Haskell, Pugatch, and McNair, 1969).

The initial intake interview has been considered by many writers to be of immeasurable

value. Lowinger and Dobie (1966) referred to the initial interview as "the point of crucial psychiatric decisions" (p. 18). It has been argued that the intake interview may be the only contact with a mental health agency upon which a client bases his/her decision on whether or not to return for treatment (Brock & Sanderson, 1984; Corazzini & Heppner, 1982). Some evidence has been gathered to show that such factors as the client's initial perception of the intake counselor's behavior and counselor and client similarity of self-disclosure can affect the percentage of clients who return for a second contact (Giannandrea & Murphy, 1973).

The timing of the intake interview would seem especially critical to counselor educators and clinic directors. Such professionals must often make decisions regarding whether or not to continue scheduling additional clients for intake interviews between quarters/semesters or at other times when counselors are not immediately available to see clients (Archer, 1984). Also inherent in this decision, however, are the risk factors associated with leaving clients who are seeking professional help on a waiting list indefinitely without evaluating their level of need for rapid or immediate service (e.g., potential for suicide, psychosis, homicide, child abuse, academic or personal disaster). Is it more appropriate ethically and in terms of benefit to clients to conduct an intake interview immediately with the understanding that clients might be forced to wait several weeks for an appointment with a counselor or to ask them to wait several weeks for the intake interview itself?

The answer to this question would seem to hinge directly on the outcome of studies such as the current study. If indeed clients do experience therapeutic benefits, such as a reduction in

anxiety or lessened feelings of depression as a result of a single intake interview, the arguement could be made to continue scheduling clients for intakes even though a counselor might not be assigned for some time. As evidence, Archer (1981) sent follow-up questionnaires to 35 students who had been placed on a four to six week waiting list and then decided to forego counseling. Twenty percent (20%) of the 25 respondents reported that the intake interview had provided enough help for them; 50% felt that counseling was no longer needed. Such findings intimate that the intake interview has had significant impact upon some clients.

It has been demonstrated that preparation of clients is necessary and effective in helping to reduce dropout rates and increasing the likelihood of positive change in therapy (Levine, Stolz, & Lacks, 1983). It would seem natural that this preparation can begin as early as the first counseling contact. In fact, many clinicians and researchers believe that psychotherapy begins the minute the intake interview begins and that much productive psychological work can be, and often is, done in one or two sessions (Pinkerton & Rockwell, 1982; Rockwell & Pinkerton, 1982).

Increasing mental health service usage and decreasing mental health budgets have forced a trend toward agencies providing more cost-effective services. Budman and Stone (1983) noted that "the pendulum is swinging back, with the goal being shorter and more efficient treatment . . . to help the patient achieve maximum benefit with the lowest investment of therapist time and patient cost, both financial and psychological" (pp. 939-940).

In concert with the recent trend within the counseling and psychotherapy literature to

investigate brief (short-term) treatment, Burlingame and Fuhriman (1987) address the ambiguity and diversity regarding brief and short-term treatments. They underscore the need for clarification regarding goals, techniques, and duration of brief therapy sessions and propose a classification scheme in an attempt to provide an integrative framework. Historically, client-counselor interactions appear to range anywhere from an intake interview only to therapy extending over several years. However, time-limited therapy (brief or short-term therapy) is generally completed in one to twelve sessions (Burlingame & Fuhriman, 1987).

The efficacy of very brief therapy has been well documented, and researchers who have compared the effectiveness of brief therapy with time-unlimited treatment have found that little difference exists (Butcher & Koss, 1978). It is the opinion of some clinicians that therapeutic impact and closure can be reached within a single interview with some clients (Spoerl, 1975) and that one or two sessions can provide sufficient help for many clients who are in crisis (Butcher & Koss, 1978).

Although it is generally accepted that benefits from therapy begin to transpire early in the therapeutic relationship and that much therapeutic work can begin as early as the intake interview (Argelander, 1976), some clinicians feel that psychotherapy begins at the moment when doctor and patient meet (Hendrickson, Coffer, & Cross, 1954). Sandifer, Hordern, and Green (1970) examined the impact of the first three minutes in a psychiatric interview with 60 patients in a public mental hospital. They found that the first three minutes of the interview had the greatest impact on final diagnoses by psychiatrists. It has also been documented that

intake interviews can reduce the number of sessions which are ultimately needed by clients and can sometimes eliminate the need for further therapy altogether (Levy, 1963). Butcher and Koss (1978), referring to the Frank et al. (1959) study, intimated that "changes in the minimal contact group result from the positive expectations of change that can be engendered by even minute expressions of professional concern" (p. 750).

Although available research underscores the initial intake interview as being of critical importance to the process and outcome of therapy, a review of literature, including the excellent review of research on brief and crisis oriented therapies by Butcher and Koss (1978), provided few studies which directly addressed the issue of client change due to this initial intake interview. Although Brischetto and Merluzzi (1981) attempted to evaluate client change, they chose to use undergraduate volunteer subjects which limited the generalizability of their findings. Bowden, Schoenfeld, and Adams (1980) administered a series of mental health ideology questions to 60 community mental health clinic patients just before their intake evaluations. Dropouts (patients terminating without mutual agreement with their therapists) were compared to patients who continued with therapy. They measured client change from before the initial intake interview but waited until after five counseling sessions had transpired before measuring a second time. Consequently, they did not attempt to measure the impact of the intake interview itself.

In the setting in which the current study was conducted, as in many other centers identified by Robison, Hutchinson, Barrick, and Uhl (1986) in a national survey of counseling centers and

training clinics, many clients are eventually referred to counselors other than the intake counselor, as these counselors-in-training become available. If the intake interview has minimal impact on clients' emotional welfare, clinic directors could be less concerned regarding the timing of intake sessions to match counselor availability. On the other hand, if the intake interview itself does reduce clients' anxiety and depression, and assuming that reduction of these emotions is accepted by professionals as inherently good, intake interviews should be conducted immediately when clients first contact the agency even though counseling cannot be provided for several weeks.

The present study was an attempt to provide evidence of either possible benefits or detriments that clients might receive from the initial session commonly referred to as the intake interview. The experimenter hypothesis predicted a reduction in both anxiety and depression as a result of the intake interview. It was hypothesized that clients in this study who experienced the intake interview before completing the assessment battery would demonstrate a lower level of pathology (reduction in anxiety and lessened feelings of depression) than those clients who completed the assessment battery first, without the possibility of the intake interview reducing anxiety and depression. Symptom change was measured by scores on the STAI STATE and the BDI.

Method

Participants

Participants consisted of 126 individuals (43 males/83 females) ranging in age from

16-66 (median age = 32) who sought counseling at a midwestern university counseling practicum clinic. Twenty-one (21) males and 41 females received Treatment 1. Twenty-two (22) males and 42 females received Treatment 2. The sample consisted of all clients age 16 and over who sought counseling at the clinic during the duration of the study. No discernable differences were found between treatment groups regarding age, educational, or socioeconomic characteristics. Clients' reasons for seeking counseling included depression, anxiety, poor self-concept, guilt, academic/school difficulties, decision-making problems, interpersonal problems, sexual concerns, marital conflicts, family conflicts, spouse abouse, child abuse, dating relationships, and grief/illness issues.

Intake Counselors

Seven advanced doctoral students were trained to serve as intake counselors and instructed to follow the usual clinic procedures in conducting intake interviews. These students were completing the second year of a post-masters doctoral program in counseling psychology and had previously worked in such agencies as comprehensive mental health centers, substance abuse centers, and inpatient clinics. They had conducted intakes, written intake reports, and staffed clients on a weekly basis under the supervision of the senior researcher. In preparation for this study, their intakes were reviewed, discussed, and inconsistencies noted and corrected to help assure conformity in style of conducting an intake interview.

General Procedures

In both treatment groups, clients 1) were told that they would be assigned to a counselor

other than the intake counselor when one became available, 2) completed a general demographics intake questionnaire, and 3) checked and rank ordered their perceptions of presenting problems from a list of 28, including an "other" category. Intake sessions were scheduled in two-hour time blocks in order to allow ample time for counselors to conduct the intake interview (45 to 50 minutes) and for clients to complete the assessment battery (45 to 50 minutes).

In order to assess the impact of the initial intake interview on the client, and as a method of randomly assigning clients without sacrificing quality of service to clients, intake interviews/assessment batteries were administered on an alternating basis. Each counselor administered an intake interview/assessment battery, in that order, to the first client seeking an intake appointment and then reversed the order (assessment battery/intake interview) with their next client, etc.

Although intake counselors were instructed to administer intake interviews and assessment batteries on an alternating basis, they were not apprised of the purpose of the study. Interviews were conducted in a neutral and usual manner with neither format nor content being altered for this study. The usual intake session at this clinic is designed to 1) identify the client's presenting problem(s), 2) assess the client's level of pathology so that an assignment can be made to an appropriate counselor-in-training, 3) establish a basic client/agency rapport, and 4) deal to some extent with any problems that need immediate attention. This is accomplished by asking the client to complete a Demographics Questionnaire, administering an assessment battery, and discussing the client's problems with them (intake interview). Subjects in both

treatment groups were treated identically in terms of assignment to a counselor following the intake session. All clients were assigned to treatment according to the usual procedures in effect at the clinic.

Treatment 1 (Assessment Battery First). The assessment battery included the Beck Depression Inventory (BDI) and the State-Trait Anxiety Invenrory-State (STAI STATE). The battery was administered by the intake counselor to participants in this treatment group immediately following the general procedures, described earlier, and before the intake interview. Following this procedure, a usual intake interview was conducted. Clients were then debriefed and questions regarding either the research or counseling at the clinic in general were answered.

Treatment 2 (Intake Interview First). The intake interview was conducted with participants in this treatment group immediately following general procedures, described earlier, and before administration of the assessment battery. Immediately following the intake interview, the assessment battery was administered. Clients were then debriefed and questions regarding either the research or counseling at the clinic in general were answered.

Instruments

Beck Depression Inventory (BDI). Many authors report that the BDI is a simple and satisfactory method of assessing level of depression (Beck, Rial, & Rickels, 1974; Clark, Gibbons, Fawcett, Aagesen, & Sellers, 1985; Johnson & Heather, 1974), a sensitive screening instrument (Gallagher, Nies, & Thompson, 1982; Nielsen & Williams, 1980), and a reliable instrument (Bouman, Luteiju, Albersnagel, & Van der Ploeg, 1985). Hill, Kemp-Wheeler, and

Jones (1986) observed that factors of the BDI measured general psychopathology, as well as aspects of depression independent of general psychopathology.

State-Trait Anxiety Inventory-STATE (STAI STATE). The STAI STATE was used to measure participants' current levels of anxiety. Metzer (1976) found the instrument to be a highly reliable measure with the ability to discriminate between high- and low-stress situations. Other authors found support for the state-trait distinction in anxiety research (Allen, 1970; Donat, 1983; Gaudry, Vagg, and Spielberger, 1975; Joesting, 1975; Johnson, 1968).

Results

Statistical analyses of the data, using t-tests, revealed no significant differences in client anxiety or depression as measured by the STAI STATE or the BDI, respectively, as a result of the experimental manipulation described above. An unexpected but interesting observation is that the results tended to fall in the opposite direction from that predicted by the experimental hypothesis.

Insert Table 1 about here

Suggestions for Further Research

Clinic administration, counselor success, and client welfare could potentially be enhanced by further research in this area. Research regarding the effects of intake interviews on client anxiety and depression is needed to precisely determine quality and quantity of client change.

For instance, time factors might be studied. It is possible that client anxiety increases during or immediately following the intake interview and then decreases with time. Is the actual amount of time (i.e., 45 minutes vs. an hour or more) spent with the client in the intake interview a significant factor?

Do female clients, male clients, or clients of various ages react differently to the intake interview? Does the gender or age of the intake counselor affect the process and outcome of the intake interview? Perhaps clients presenting particular problems or problems of lesser or greater severity react differently to the intake interview. Does the theoretical orientation of the intake counselor impact upon the initial interview? The effect of a client being assured that they will be assigned to a specific counselor might be explored. Does the possible non-commitment of the intake interviewer have an effect on the counseling relationship? It must also be realized that the effect of the reduction or enhancement of levels of anxiety or depression, as a result of the intake interview, has not been satisfactorily determined.

Conclusions and Implications

As was the case in the current study, it is possible that talking about presenting problems with an intake counselor may actually serve to intensify symptomatology in some clients rather than to reduce it. For instance, levels of client anxiety or depression might actually be increased rather than decreased as a result of clients discussing with a counselor problems which have been troubling them.

Considering these findings, we are concerned that two assumptions have been accepted for

some time which could be leading us up the wrong track in this line of research: 1) it has not been definitely determined whether or not a single intake interview decreases or increases anxiety or depression in most clients; and 2) it seems presumptuous to assume that a reduction in clients' anxiety and/or depresssion is inherently good.

These findings differ from some previous research which has generally underscored the critical impact of a single assessment interview. Stress and depression levels were actually increased in some clients immediately following their intake interview. These results add impetus to the argument that the importance of a single assessment (intake) interview, in terms of client welfare, has perhaps been overrated.

Such findings have potential to aid counselor educators or directors of training clinics in their decision making. These professionals often must make decisions regarding assignment of clients based on counselor availability. In light of the results of this study, the decision regarding whether or not to conduct an intake interview immediately with clients on a waiting list rather than have them wait until a counselor can actually be assigned seems less crucial. If the reduction in anxiety and lessened feelings of depression are accepted as therapeutically beneficial to clients, it is indeed possible, if not probable, that the welfare of some clients is better served by waiting until a counselor can immediately be assigned before conducting an intake interview. This, of course, would preclude those clients who might be in need of immediate attention (e.g., potential for suicide, psychosis, homicide, child abuse, academic or personal disaster, etc.).

Such findings have ethical and professional implications for directors of counselor training clinics who are responsible for balancing the client waiting list with counselor availability. It is hoped that the findings of this study will stimulate further research in this area.

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Table 1

Effects of an Intake Interview on Clients' Anxiety and Depression

	STAI STATE	BDI
Battery First	n = 57	n = 61
	M = 46.947	M = 11.557
	s = 15.595	s = 9.286
Interview First	n = 57	n = 65
	M = 47.684	M = 13.323
	s = 14.311	s = 9.262
	t = 0.263	t = 0.468
	$p > .05$	$p > .05$